

CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS

With the increasing awareness of a patient's right to confidentiality, we are asking all of our patients to complete this form. It will give the doctors and staff guidance as to who should be allowed to receive verbal information about your health care.

*Please complete **ONE** of the 3 options listed below:*

1. **Do not discuss my medical condition with anyone other than my doctors and professionals who are involved in my healthcare.**

*If you chose this option, **STOP HERE** then sign and date at the bottom.*

2. **No Restrictions** (May discuss with anyone).

*If you chose this option, **STOP HERE** then sign and date at the bottom.*

3. **I, _____, give the physicians and office staff of Sacramento Clinic for Hematology and Medical Oncology permission to discuss my medical condition with the following individuals:**

Name: _____

Relationship: _____ Phone # (_____)

and/or (Name): _____

Relationship: _____ Phone # (_____)

and/or (Name): _____

Relationship: _____ Phone # (_____)

and/or (Name): _____

Relationship: _____ Phone # (_____)

This consent is in force indefinitely unless you fill in an expiration date or you revoke this consent in writing.

X

Patient Signature

Signature Date

Printed Name

Consent Expiration Date (If any)